TRIARC
GUARDRISK TAILORED RISK SOLUTIONS
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TRIARC is an authorised financial services provider FSP45009

DISABILITY FUNCTIONAL IMPAIRMENT FORM

Please complete form in block letters

Policy Number

Important

- An accurately completed form is essential in order to avoid delays in the assessment process. A claim can be considered only if all required documents and all the supplementary statements (as indicated below) have been completed in full and are in Triarc's possession.
- It is also important that you should be aware of the implications of the non-payment/payment of this claim for your financial position. We therefore strongly recommend that at this stage that you should already contact Triarc to assist you in this regard.
- This form and all relevant documents can be sent to us by e-mail or by post. If legible copies of documents are provided to us, the original documents will not be required.
  Please note: A claim can only be submitted for the claim events as stipulated in the contract, on all the above-mentioned benefits.

Section 1. Particulars of Policyholder

Surname

First Name(s)

ID Number

Date of Birth (Y Y Y Y M M D D) Gender (F M) Title

Passport No. Date of Expiry (Y Y Y Y M M D D)

Country of Issue

Maiden Name

Telephone Number

Cellphone

Email Address

Marital Status Single Married Divorced Other

Residential address

Suite/ unit number Complex Name

Street Number Street Name

Suburb City

Region Postal Code

Section 2. Nature of Claim and Particulars of Consultations

For what contractual listed illness, injury or deviations are you claiming?

State the date from which the illness or injury was first experienced. Y Y Y Y M M D D

Describe the illness or injury.

State from which date the illness or injury was experienced. Y Y Y Y M M D D

On which date did you consult a doctor regarding these symptoms for the first time? Y Y Y Y M M D D

State the initials, surname, address, and telephone number of this doctor.

Telephone Number

Fax Number

Section 3. Medical History

State the initials, surname, address, and telephone number of:

Present Family Doctor

Telephone Number

Previous Family Doctor

Telephone Number

Since when have you been consulting your present Family Doctor? Y Y Y Y M M D D

On what date did you last consult your present Family Doctor Y Y Y Y M M D D

Provide the following information with regards to all other Doctors or Specialists you have consulted regarding the condition that gave rise to this claim.

Details of Doctors, Specialists and Consultations

Name and Surname	Type of Specialist	Address	Telephone No.	First Consultation

Particulars of Injury

Date of injury Y Y Y Y M M D D

Place of injury

The injury was caused by:

- ☐ Motor vehicle accident
- ☐ Accident at home
- ☐ Shooting accident
- ☐ Other Specify _____

Give a brief description of how the accident happened.

If there was an investigation into the cause of the injury or illness, provide the following information:

Name of the Police Station:

Case Number:

Initials and Surname of Investigating Officer

Contact details: Telephone | Fax

Findings of the investigation (provide copy of the SAPS report/Report of injury sustained at work/Court report.

Did you suffer any physical loss? Yes No

If "Yes, describe the nature of the loss you suffered.

If the loss did not occur on the date of the accident, please state the date on which the loss took place.

Y Y Y Y M M D D

Section 4. Declaration by Employer

Particulars of Employer

Full Names and Surname / Name of Institution

Name of Group Scheme (only if applicable)

Employee reference number of claimant

Postal address

Suite/ unit number | Complex Name

Street Number | Street Name

Suburb | City

Region | Postal Code

Contact details: Telephone | Fax

E-mail address

General Information

Date of appointment Y Y Y Y M M D D

Name of occupation

Date of appointment in this occupation | Y | Y | Y | Y | M | M | D | D |

Date of official discharge | Y | Y | Y | Y | M | M | D | D |

Define the essential functions of this occupation: **Please attach a non-generic job description.**

Last date on which claimant was still actively able to perform his/her job. | Y | Y | Y | Y | M | M | D | D |

Date of official discharge | Y | Y | Y | Y | M | M | D | D |

State the number of hours the claimant engaged in the actions below. (Note: The hours must add up to the hours the client worked). Please indicate the specific actions performed per hour.

Administrative duties		
Manual/physical duties		
Supervisory duties		
Travelling by car, truck, etc.		
Walking and standing		
Total hours		

Please state the academic qualifications of the claimant

Gross average monthly salary before disability		
	Basic	R
	Overtime	R
	Other	R
Gross average monthly salary after disability	Basic	R
Gross monthly pension after disability		R

Description of employee's disability (functional impairment)

What is the cause of his/her disability?

When did you first become aware of the condition? | Y | Y | Y | Y | M | M | D | D |

Was the cause an injury sustained while on duty? Yes ☐ No ☐

If "Yes", please provide us with the Injury sustained at work – report.

Current works status (Please mark the applicable option)

Still at work	☐
Working part-time	☐
On sick leave	☐
Early retirement due to ill health	☐
Working in alternative position	☐
Gross monthly pension after disability	☐

If this option is selected, please answer the following questions:

If the person was not considered for an alternative position, was it as a result of:

Was the cause an injury sustained while on duty? Yes ☐ No ☐

Was the cause an injury sustained while on duty? Yes ☐ No ☐

If the person accepted an alternative position, please answer the following questions:

Did the aspect mentioned below contribute to his/her appointment to the alternative position? Please provide reasons.

Training	Yes		No		
Experience	Yes		No		
Education	Yes		No		

Description of employee's disability (functional impairment)

Alternative position (continue)

Describe in full what his/her duties in the alternative position comprise and indicate exactly the nature of what he/she now does. (For example, it is not sufficient to say "He/she performs light clerical work"- please indicate the nature of the clerical work):

State the number of hours the client engaged in the actions below. (Note: The hours must add up to the hours the client worked). Please indicate the specific actions performed per hour.

Administrative duties		
Manual/physical duties		
Supervisory duties		
Travelling by car, truck, etc.		
Walking and standing		
Total hours		

Educational qualifications required for the alternative position

Gross earnings in the alternative position

Basic	R
Overtime	R
Other	R

Has he/she been appointed on a part-time or permanent basis? Part-time ☐ Permanent ☐

Has he/she been appointed on a part-time or permanent basis? Yes ☐ No ☐

Is this status of the alternative position higher than, equal to or lower than the position previously held?

Please provide the reasons if an alternative position was offered, but the claimant did not accept the position.

Sick Leave Records

Please provide us with a brief summary of all sick leave of longer than 2 days taken by the claimant during the past two years. Please include copies of the relevant doctor's certificates.

Illness or injury	Name of doctor(s) consulted	Dates from work		Total days absent
		From (dd/mm/ccyy)	To (dd/mm/ccyy)	

Contact person with regards to sick leave records

Contact details: Telephone | | | | | | | | | | Fax | | | | | | | | | | |

E-mail address

I hereby declare that the information provided within is correct and no information was withheld.

Name and Surname of authorized official

Capacity of authorised official

Signature of authorised official | Date Y Y Y Y M M D D

Signed at

Official stamp of Institution

Section 5. Payment Details

Payment to the owner of the Policy

If the claim of the Life Insured is approved, Triarc is able to make the money available by means of an Electronic Funds

Account holder Name

Bank Name

Branch Name | Branch Code | | | | | | |

Account Number

Account Type ☐ Cheque ☐ Transmission ☐ Savings

I the undersigned, hereby declare that the above information is true and correct and confirm that Triarc will not be held liable for any loss that may arise from the use of this information.

Signature of Authorised Person | Date Y Y Y Y M M D D

Section 6. Declaration

I declare that the particulars contained in this form are true and correct. I also irrevocably authorize any Person or institution, Medical Practitioner, Medical Specialist, Hospital, Nursing Institution or Medical Authority to provide Triarc with any information that may be required regarding my health. Further, I irrevocably authorize Triarc to share t-with other insurers that information and any information contained in this proposal or any related plan or other document, either directly or through a database operated by or for insurers as a group, at any time (even after my death) and in such detailed, abbreviated or coded form as may from time to time be decided by Triarc or by the database operators.

Signature of Authorised Person		Date	Y	Y	Y	Y	M	M	D	D

Section 7. Declaration by Claimant

I declare my answers and statements are true and correct and I have not omitted or withheld any material fact from Triarc.

I understand and accept that it may be necessary for Triarc to disclose the benefit payment details to the policyholder, beneficiaries and/or their respective agents.

Triarc is authorised to make payment as instructed and I acknowledge that payment, by Triarc of the benefits claimed, will release Triarc and Guardrisk Life Limited from all liability for such benefits.

Name and Surname										
Signed at										
Signature		Date	Y	Y	Y	Y	M	M	D	D

Section 9. Processing of Personal Information on terms of the Protection of personal Information Act 4 of 2013

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by you or which is collected from you is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner and kept for the period prescribed by the Applicable Laws.

You hereby agree to give honest, accurate and up-to-date Personal Information which may be used for the following reasons:

1. to establish and verify your identity in terms of the Applicable Laws;
2. to enable Us to fulfil our obligations in terms of this Claim;
3. to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share your information for further processing with the following third parties, which third parties have an obligation to keep your Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks, and other persons that assist with the processing of any benefit payable.
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime.
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that we, in accordance with the Applicable Laws, are required to share your Personal Information with; and
4. Credit Bureau's.

You acknowledge that any Personal Information supplied to Us in terms of this Claim is provided according to the Applicable Laws. Unless consented to by yourself, We will not sell, exchange, transfer, rent or otherwise make available your Personal Information to any other parties and you indemnify Us from any claims resulting from disclosures made with your consent. Such Personal Information provided (voluntarily, unconditionally, and specifically) will be utilised by Us or by any appointed third parties, on our behalf, and will be kept for such period as legislated according to the Applicable Laws.
You understand that if We have utilised your Personal Information contrary to the Applicable Laws, you have the right to lodge a complaint with Guardrisk within 10 (ten) days. Should Guardrisk not resolve the complaint to your satisfaction, you have the right to escalate the complaint to the Information Regulator.

Name and Surname	
Signed at	

Signature		Date	Y Y Y Y M M D D

Annexure A – Supporting Documents

The following supporting documentation must be submitted:

Policyholder	
Certified Copy (by a Commissioner of Oaths) of your Identity document or back and front copies of the Identity card	
Copies of all available medical reports, X-Rays, MRI scans and special medical tests done	
SAPS report or reports of injury sustained at work if a claim was caused by an accident on duty, as well as the result of the investigation if already finalized	
The attached reports by the treating specialist	
Copies of payslips for the last 3 months	
Sick leave certificates	
Copy of job description issued by employer	